U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 12 March 2007

CASE NO. 2005-BLA-6204

In the Matter of

E.M.,
Claimant

v.

CONSOLIDATION COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Ron Carson, Director, Stone Mountain Health Services
Lynda D. Glagola, Program Director, Lungs at Work
For the Claimant[1]

Ashley M. Harman, Esquire
Jackson & Kelly, PLLC
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim for benefits filed by E.M., a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. § 901, *et seq*. Regulations implementing the Act have

[1] Ron Carson appeared at the formal hearing as Claimant's representative (TR 4). However, Lynda D. Glagola submitted the post-hearing brief on Claimant's behalf.

been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[2]

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on August 1, 2006, in Charleston, West Virginia. At that time, all parties were afforded full opportunity to present evidence and argument as provided in the Act and Regulations. Furthermore, the record was held open to allow for the submission of post-hearing evidence and closing briefs (TR 8, 25-26).[3]

At the hearing, Director's Exhibits 1 through 44 (DX 1-44), Claimant's Exhibits 1 through 5 (CX 1-5), and Employer's Exhibits 1 through 10 (EX 1-10) were admitted in evidence. In "Employer's Index of Exhibits," Employer had identified two of its post-hearing submissions; namely, Dr. Fino's deposition, dated August 7, 2006, and Dr. Rasmussen's deposition, dated September 11, 2006, as Employer's Exhibits 11 and 12, (EX 11, 12). These exhibits were submitted under cover letters, dated August 18, 2006 and September 11, 2006, and have been marked and received in evidence as Employer's Exhibits 11 and 12 (EX 11, 12). In addition, Employer submitted the "rebuttal" x-ray interpretations of Dr. Meyer of films, dated August 22, 2005 and October 20, 2005. These rereadings have been marked and received in evidence as Employer's Exhibits 13 and 14 (EX 13, 14), respectively. Finally, Employer submitted Dr. Renn's deposition, taken on October 12, 2006, under cover letter, dated November 14, 2006. This document has been marked and received as Employer's Exhibit 15 (EX 15).[4]

In summary, the record consists of the hearing transcript, Director's Exhibits 1 through 44 (DX 1-44), Claimant's Exhibits 1 though 5 (CX 1-5), and Employer's Exhibits 1 through 15 (EX 1-15). In addition, I have received and considered the post-hearing briefs submitted on behalf of the respective parties.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, testimony presented, and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

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[2] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 Regulations became effective on January 19, 2001. Since the current claim was filed on March 10, 2004 (DX 5), the new Regulations are applicable (DX 44).

[3] The following abbreviations are used in this Decision: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, and TR = transcript of the August 1, 2006 hearing.

[4] Dr. Renn's deposition transcript was admitted even though it was filed after the November 1, 2006 deadline, because there was no objection thereto, and, Claimant has not been prejudiced by the late submission (TR 26).

Procedural History

Claimant, E.M., filed his initial application for federal black lung benefits on September 8, 1995, which was denied by the District Director's office on March 9, 1996 (DX 1). Claimant did not appeal nor seek modification of this denial. Accordingly, the September 8, 1995 claim is finally denied and administratively closed (DX 42).

On July 21, 1997, Claimant filed a second claim for benefits under the Act, which was denied by the District Director's office on January 12, 1998 (DX 2). Claimant did not appeal nor pursue the claim. Therefore, the July 21, 1997 claim is finally denied and administratively closed (DX 42).

On January 31, 2001, Claimant filed a third application for benefits under the Act, which was denied by the District Director in a Proposed Decision and Order, dated November 14, 2002 (DX 3). Claimant did not appeal nor pursue the claim. Therefore, the January 31, 2001 claim is also finally denied and administratively closed (DX 42).

On March 10, 2004, Claimant filed the current application for black lung benefits under the Act (DX 5), which was initially denied by the District Director in a Proposed Decision and Order, dated January 18, 2005 (DX 30). On or about March 22, 2005, Claimant submitted correspondence, which was accepted by the District Director's office as a modification request (DX 32, 34). On June 6, 2005, the District Director's office issued a Proposed Decision and Order Granting Request for Modification, in which benefits were awarded (DX 36). Following Employer's timely request for a formal hearing (DX 37), this matter was referred to the Office of Administrative Law Judges for *de novo* adjudication (DX 42-44). As stated above, a formal hearing was held before the undersigned on August 1, 2006. The record was closed upon receipt of the parties' closing arguments on or about November 16, 2006.

Issues

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?
II. Whether the miner's pneumoconiosis arose out of coal mine employment?
III. Whether the miner is totally disabled?
IV. Whether the miner's disability is due to pneumoconiosis?
V. Whether the evidence establishes a material change in conditions per 20 C.F.R. § 725.309?
VI. Whether the evidence establishes a change in conditions and/or a mistake in a determination of fact per 20 C.F.R. § 725.310?

(DX 42; TR 12-14).

Findings of Fact and Conclusions of Law

Background

A. Coal Miner and Length of Coal Mine Employment

On his current application for benefits, Claimant alleged that he worked in and around the coal mines for "25" years (DX 5). On earlier applications, Claimant had alleged 37 (DX 1, 2) and "25-35" years (DX 3) of such employment. However, the District Director found that Claimant had established at least 26 years of coal mine employment (DX 12, 34). Moreover, the parties stipulated to 26 years of coal mine employment (TR 12). The discrepancy in the number of years of coal mine employment, as alleged by Claimant and/or reported by various physicians, may be related to the fact that Claimant's twenty-six (26) years of coal mine employment occurred over a forty-five (45) year period, beginning in 1945 and ending in 1990 (DX 12).[5] Based upon the stipulation of the parties, I find that Claimant has established 26 years of coal mine employment. Furthermore, in view of this extensive coal mine employment history, I find that any discrepancy in the exact number of years of such employment is inconsequential for the purpose of rendering this decision.

B. Timeliness of Filing

Claimant filed his application for benefits under the Act on March 10, 2004 (DX 5). There is a rebuttable presumption that the claim is timely filed. 20 C.F.R. § 308(c). This presumption has not been rebutted.

C. Responsible Operator

Consolidation Coal Company stipulated, and I find, that it is the properly designated responsible operator in this case, under Subpart G, Part 725 of the Regulations (TR 12).

D. Dependency

Claimant has one dependent for the purpose of augmentation of benefits under the Act; namely, his wife. (DX 5, 14; TR 23).

E. Personal, Employment, and Smoking History

Claimant was born on October 4, 1928; he had a 5th grade education. Claimant's wife is his only dependent for the purpose of augmentation of benefits under the Act. Claimant engaged in coal mine employment for 26 years ending in 1990 (DX 5, 8, 12; *compare* TR 18). All of his coal mine employment was spent underground, primarily at the face of the mine (TR 17-18).

[5] The District Director's office apparently did not credit Claimant for the $24.00 earned while working for Malone Coal Company, in 1945; the $56.00 earned in 1950 working for Johnson Coal Company; and/or, the $55.15 earned in 1951, while working for Lillian Coal Company (DX 12). Nevertheless, the District Director's finding is, generally, quite accurate.

Claimant's last usual coal mine job was as a bolter operator for Employer. The job entailed extensive walking and carrying (TR 16-17).

Claimant testified that his breathing problems began in 1971 but the condition has worsened over the years (TR 18-19). Claimant stated that he is currently seeing Dr. Carl Myers and Dr. San Pablo for his breathing condition. Claimant has been on oxygen for 12 years, which was prescribed by Dr. San Pablo, who has treated him for about fifteen years (TR 20-21). In addition, Claimant uses Combivent inhalers, Atrovent, Theo-Dur; and he also recently began taking breathing pills. Claimant testified that his medication has increased significantly over the past four years (TR 21-22).

Claimant testified that he started smoking cigarettes when he joined the Army, at age 16 or 17 (*i.e.,* 1944 or 1945). Claimant stated that he smoked ½ pack per day when he was smoking, but that he sometimes smoked "off and on" and/or "slowed down." Claimant testified that he has cut back to about five cigarettes per day (TR 22-23). Accordingly, Claimant has acknowledged an ongoing cigarette smoking history which started more than 60 years ago. Moreover, the Davis Memorial Hospital History and Physical report, dated January 9, 2005, states, in pertinent part: "SOCIAL HISTORY: The patient is a current smoker, still smokes about 5 to 6 cigarettes per day. However, use (sic) to be a heavy smoker. The patient also has a history of working in the coal mines." (EX 1). Claimant's reported history as a "heavy smoker," suggests that Claimant smoked more than ½ pack per day. Furthermore, the medical records, dated December 13, 1976, submitted in conjunction with the West Virginia Occupational Pneumoconiosis claim, state that Claimant smoked up to 1½ - 2 packs per day starting at age 17 (DX 3). Moreover, even if Claimant smoked an average of ½ pack per day beginning in 1944 or 1945, he still has an extensive cigarette smoking history.

Medical Evidence

The medical evidence includes various recent x-ray interpretations, pulmonary function studies, arterial blood gas studies, and physicians' opinions, including treatment records, which were submitted since the final denial of the most recent prior claim, as summarized below.

A. Chest X-rays

The case file contains interpretations of recent chest x-rays, dated December 1, 2003 (EX 6), March 23, 2004 (DX 19, 20; CX 3; EX 4), January 8, 2005 (EX 1), February 15, 2005 (EX 1), July 13, 2005 (CX 5; EX 2), August 15, 2005 (EX 6), August 22, 2005 (CX 2; EX 13), and, October 19-20, 2005 (CX 1; EX 14).

The above-listed x-rays include several which are contained in the treatment records, which are not subject to the evidentiary limitations. These include "normal chest exam" readings by Dr. Koay and Dr. Barnett of portable chest x-rays, dated January 8, 2005 and February 15, 2005, respectively (EX 1). However, the quality of these films is not noted. Moreover, the radiological credentials of Drs. Koay and Barnett are not in evidence. Therefore, I accord these interpretations less weight.

The treatment records also include descriptive interpretations of chest x-rays, dated December 1, 2003 and August 15, 2005 by Dr. Migaiolo and Dr. Barnett, respectively (EX 6). These descriptive interpretations do not specify a diagnosis of pneumoconiosis. However, they reveal abnormalities, such as atelectasis or infiltrate and/or COPD, which do not preclude a finding of pneumoconiosis. Furthermore, the quality of the films and the qualifications of these physicians are not in the record. In view of the foregoing, these descriptive interpretations are also accorded less weight.

The chest x-ray, dated March 23, 2004, was interpreted as positive for (1/0) pneumoconiosis by Drs. Thomeier and Gohel (DX 19; CX 3, respectively). However, Dr. Meyer interpreted the same film as negative for pneumoconiosis (EX 4).[6]

The chest x-ray, dated July 13, 2005, was interpreted as positive for (1/1) pneumoconiosis by Dr. Colella (CX 5). However, Dr. Renn interpreted the same film as negative for pneumoconiosis (EX 2).

The chest x-ray, dated August 22, 2005, was interpreted as positive for (1/1) pneumoconiosis by Dr. Gohel (CX 2). However, Dr. Meyer interpreted the same film as negative for pneumoconiosis (EX 13).

The chest x-ray, dated October 19-20, 2005, was interpreted as positive for (1/0) pneumoconiosis by Dr. Cohen (CX 1). However, Dr. Meyer interpreted the same film as negative for pneumoconiosis (EX 14).

Except for Dr. Barnett and the "treatment records physicians," all of the above-listed physicians are B-readers. Moreover, Drs. Thomeier, Gohel, Meyer, and Colella are dual-qualified B-readers and Board-certified radiologists.

In summary, all five of the positive interpretations were rendered by B-readers, including four by dual-qualified B-readers and Board-certified radiologists. On the other hand, only four of the negative interpretations were rendered by B-readers, including three by dual-qualified B-readers and Board-certified radiologists. As fact-finder, I have weighed the quality and quantity of the conflicting x-ray evidence. Based upon the foregoing, I find that Claimant has met his burden and established the presence of simple pneumoconiosis by a preponderance of the x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The Regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

[6] Dr. Binns, a B-reader and Board-certified radiologist reread the x-ray, dated March 23, 2004, for quality purposes only, and reported the film quality as "1" (*i.e.,* "Good"). (DX 20).

The record contains recent pulmonary function studies, dated March 23, 2004 (DX 18), July 13, 2005 (EX 2), October 20, 2005 (CX 1), and June 26, 2006 (CX 4). All of the studies (before and after bronchodilator) are qualifying under the applicable criteria set forth in Part 718, Appendix B, based upon qualifying FEV1 values and FEV1/FVC ratios of less than 55%. Accordingly, I find that the pulmonary function studies establish the presence of a total (pulmonary or respiratory) disability.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes arterial blood gas studies which were administered on March 23, 2004 (DX 17), July 13, 2005 (EX 2), October 20, 2005 (CX 1), and June 26, 2006 (CX 4). None of the studies (resting or exercise) are qualifying under the applicable criteria set forth in Part 718, Appendix C. Accordingly, I find that the arterial blood gas studies do not establish the presence of a total (pulmonary or respiratory) disability.

D. Physicians' Opinions[7]

The case file contains recent hospital and treatment records (EX 1, 6), and the medical opinions of Drs. Celko (DX 16; EX 7), Renn (EX 2; EX 15), Cohen (CX 1), Fino (EX 8, 11), and Rasmussen (CX 4; EX 12).

The Davis Memorial Hospital and Broaddus Hospital Association records and treatment notes cover various periods of treatment during the period from December 1, 2003 through August 15, 2005 (EX 1, 6). These records confirm that Claimant was treated on several occasions for shortness of breath. The diagnosed conditions include: acute exacerbation of chronic obstructive pulmonary disease, diabetes mellitus, type II, controlled, coronary artery disease, hypertension, cigarette smoker, hyperlipidemia, hypothyroidism, osteoarthritis, multiple joints, diabetic neuropathy, gastritis, and allergic rhinitis (EX 1, 6). These records do not include a specific diagnosis of clinical pneumoconiosis. Furthermore, the references to cigarette smoking suggest that the hospital physicians may relate Claimant's chronic obstructive pulmonary disease to his extensive smoking history. However, the hospital records do not address Claimant's 26-year history of coal mine employment as a possible contributing factor. In fact, Claimant's history of working in the coal mines is rarely cited in the records. Accordingly, I find that the absence of a diagnosis of pneumoconiosis from the hospital treatment records does not preclude a finding of pneumoconiosis.

[7] Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. *See, Harris v. Old Ben Coal Co.*, 23 BLR 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006); *see also, Webber v. Peabody Coal Co.*, 23 BLR 1-123, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc).

Dr. David A. Celko is Board-certified in Internal Medicine and primarily practices pulmonary medicine (EX 7, pp. 4-6). Dr. Celko examined Claimant on April 5, 2004 (DX 16). On a U.S. Department of Labor form, Dr. Celko referred to Claimant's attached Employment History form, dated March 11, 2004 (DX 16, Sec. B). Dr. Celko also set forth Claimant's family, medical, and social history. The latter included a cigarette smoking history of ½ pack per day beginning at age 18 (*i.e.,* 1946) and stopping in 2004 (DX 16, Sec. C3). Dr. Celko also noted Claimant's complaints of sputum, wheezing, dyspnea, cough, ankle edema, and paroxysmal nocturnal dyspnea (DX 16, Sec. D1). Physical findings on examination of the thorax and lungs included some abnormal findings, such as obesity and decreased breath sounds (DX 16, Sec. 4). Dr. Celko also administered and/or obtained various clinical test results, and reported the following "Summary of Results:"

Chest X-ray:	Pneumoconiosis ILO P/P, perfusion 1.0
Vent Study (PFS):	Severe obstructive vent pattern; no response, mild decrease DLCO
Arterial Blood Gas:	Normal resting abgs.
	Exercise: Hypercarbia, decreased PaO2; audible wheezing
Other: ECG	low voltage standard leads; NSR

(DX 16, Sec. D5).

Under the Cardiopulmonary Diagnoses section of the U.S. Department of Labor form report, Dr. Celko listed the following diagnoses: "(a) COPD with asthma (b) pneumoconiosis (c) sleep disturbance" (DX 16, Sec. D6). Dr. Celko reported the etiologies of the diagnosed conditions, as follows: "(a) cigarette smoking & occupational dust exposure (b) occupational dust exposure (c) obesity" (DX 16, Sec. D7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Celko stated: "totally & permanently impaired from respiratory standpoint" (DX 16, Sec. D8a). When asked the extent to which each of the diagnosed conditions contributes to Claimant's impairment, Dr. Celko stated: "[Claimant] worked as an underground coal miner x 45 years. He smoked ½ ppd cigarettes x 57 years. It is my opinion that although both are significant, the occupational dust exposure is the most substantial contributing factor to his pulmonary disease as shown by both PFTs & X-rays." (DX 16, Sec. D8b).

Dr. Celko provided deposition testimony on September 1, 2005 (EX 7). He stated that the decreased diffusion capacity is consistent with centrilobular emphysema and tobacco smoke induced lung disease. However, Dr. Celko also stated that obstructive changes can be due to coal mine dust exposure. Although he could not delineate the extent to which each may have contributed, Dr. Celko also referred to unspecified medical literature, which indicated that the coal dust exposure is less likely to cause this degree of obstruction than tobacco consumption (EX 7, pp. 26-27). However, Dr. Celko reiterated that, in his opinion, Claimant suffers from disabling COPD, which would prevent him from returning to his coal mine work. Furthermore, Dr. Celko expressly stated that Claimant's significant cigarette smoking history and dust exposure both contributed to Claimant's total respiratory disability (EX 7, p. 34-35).

Dr. Joseph J. Renn, III, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 3), examined Claimant on July 13, 2005. In his report, dated August 16, 2005 (EX 2), Dr. Renn set forth Claimant's occupational history, cardiopulmonary history, tobacco history, medications, personal history, family history, past medical history, and review of systems. On physical examination, Dr. Renn reported that the "lungs are clear to palpations. Auscultation reveals prolongation of the expiratory phase and diffuse expiratory wheezes. There are no crackles." Dr. Renn's laboratory evaluation included, in pertinent part: serum nicotine and cotinine levels consistent with a person exposed to nicotine within the past month; abnormalities on electrocardiograph; a chest x-ray reading of calcified granulomata, emphysema, old healed rib fractures, plate atelectasis, and increased bronchovascular markings, but no parenchymal or pleural abnormalities consistent with pneumoconiosis; a spirometry indicated severe obstructive defect with significant improvement following inhaled bronchodilator; lung volumes showed hyperinflation and air trapping; diffusing capacity testing was deemed invalid; carboxyhemoglobin level was consistent with a person smoking approximately ½ pack per day. In addition, Dr. Renn listed other medical data. In summary, Dr. Renn set forth the following diagnoses of the respiratory system:

1. Chronic bronchitis owing to tobacco smoking.
2. Pulmonary emphysema owing to tobacco smoking.
3. Extrinsic allergic asthma.
4. A pneumoconiosis does not exist.
5. Plate atelectasis owing to . . . [severe exogenous obesity]
6. Severe, significantly bronchoreversible obstructive ventilatory defect owing to #1, #2 and #3 above.

In conclusion, Dr. Renn stated:

> **DISCUSSION:** It is with a reasonable degree of medical certainty that none of the above diagnoses were either caused, or contributed to, by his exposure to coal mine dust. It is with a reasonable degree of medical certainty that his chronic bronchitis and pulmonary emphysema resulted from his years of tobacco smoking rather than his exposure to coal mine dust.
>
> It is with a reasonable degree of medical certainty that he is totally and permanently impaired to the extent that he would be unable to perform either his next-to-last known coal mining job of general inside laborer or his last known coal mining job of roofbolter or any similar work effort.

(EX 2).

Dr. Renn provided deposition testimony on October 12, 2006, in which he reiterated the above-stated opinion (EX 15). Dr. Renn stated, in pertinent part, that the timing of Claimant's sputum production, the pattern of an elevation in total lung capacity, more marked elevation of residual volume, increase in the residual volume/total lung capacity ratio, and reduction of diffusing capacity are consistent with tobacco-related pulmonary diseases, such as chronic bronchitis and pulmonary emphysema, and are not typical of industrial bronchitis and/or coal workers' pneumoconiosis (EX 15, pp. 10-12).

Dr. Robert A.C. Cohen is a B-reader who is Board-certified in Internal Medicine and Pulmonary disease (CX 1). In his report, dated December 9, 2005, Dr. Cohen set forth Claimant's history of present illness, past medical history, past surgical history, medications, allergies, smoking history, family history, and occupational history. On physical examination, Dr. Cohen reported the following lung findings: "Vesicular Breath sounds, B/L wheezes heard, No Crackles." In addition, Dr. Cohen cited a positive x-ray reading for pneumoconiosis; pulmonary function results including a normal FVC, but severely impaired FEV1 and FEV1/FVC ratio, with no clear response to bronchodilators. The lung volumes revealed increased RV and RV/TLC ratio. There was moderate diffusion impairment. Arterial blood gases were normal for Claimant's age. The above-referred results were interpreted as follows: "Impression: Severe obstructive defect with moderate diffusion impairment. The reduction in diffusion with low D1/Va indicates an altered gas exchange surface." In addition, Dr. Cohen reviewed and summarized other available medical data. Furthermore, he answered various medico-legal questions.

In summary, Dr. Cohen diagnosed pneumoconiosis based upon the following: Claimant's 26 years of coal mine employment and resulting significant coal dust exposure; symptoms consistent with chronic lung disease; pulmonary function testing; and, positive x-ray evidence of pneumoconiosis. Dr. Cohen also noted a one year history in a steel mine would be expected to only make a small contribution; and, he cited other diagnoses which could contribute to dyspnea but would not result in an obstructive defect. In addition, Dr. Cohen discussed the relationship of obstructive lung disease and coal dust exposure, citing various articles of medical literature. Furthermore, Dr. Cohen discussed the pulmonary function tests and found that they demonstrated that Claimant could not perform his last usual coal mine job. In conclusion, Dr. Cohen stated:

> It is my opinion that the sum of the medical evidence in conjunction with this patient's work history indicates that [Claimant's] 26 years of coal mine dust exposure as well as his 32 pack years of exposure to tobacco smoke was [sic] significantly contributory to the development of his pulmonary dysfunction including severe obstructive lung disease and moderate to severe diffusion impairment. His resulting combined respiratory impairment is disabling for his last coalmine job.

(CX 1).

Dr. Gregory J. Fino, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease (EX 9), issued a report, dated June 23, 2006, in which he provided a summary of the available evidence (EX 8). In addition, Dr. Fino's report cites various British, Italian, French, and American studies which address the extent of the drop in FEV1 values in miners. In summary, Dr. Fino stated:

> This man's x-ray is not particularly abnormal and he does not have a prolonged period of time within the coal mines. Also, almost all of his working years occurred after dust regulations. Therefore, the average response to coal mine dust

retention in his lungs would be a loss of 3 cc of FEV1 per year worked, for an approximate total of 60 cc.

I cannot contribute more than 360 cc of FEV1 loss to coal mine dust. However, this man lost more lung function than 360 cc. He has lost 2000 cc of FEV1 over the years. Therefore, if we could give this man 260 cc of FEV1, his FEV1 would increase to 1.24 liters and he would still be disabled. There is another process causing the significant drop in FEV1 and I believe that it is clearly and unequivocally cigarette smoking. Having reviewed all of the information in this case, I can state with a reasonable degree of medical certainty that this man is disabled as a result of smoking-induced emphysema and chronic obstructive bronchitis. Coal mine dust did not cause, contribute to or hasten his disability.

Conclusions

1. There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis.

2. There is a disabling respiratory impairment due to cigarette smoking.

3. From a respiratory standpoint, this man is disabled from returning to his last mining job or a job requiring similar effort.

4. Even if I were to assume that the man has coal workers' pneumoconiosis, it has not contributed to his disability. He would be as disabled had he never stepped foot in the mines.

(EX 8). Dr. Fino reiterated the above-stated opinion in his deposition testimony on August 7, 2006 (EX 11, pp. 21-27).

Dr. Donald L. Rasmussen is a B-reader who is Board-certified in Internal Medicine and Forensic Medicine. Although Dr. Rasmussen is not Board-certified in pulmonary medicine, he received his training in that field. Furthermore, Dr. Rasmussen has evaluated thousands of coal miners throughout his years of practice, mostly at the request of the U.S. Department of Labor, published various articles, and testified before Congress on several occasions regarding coal workers' pneumoconiosis (CX 4; EX 12, pp. 4-5). In view of the foregoing, I find that Dr. Rasmussen has excellent pulmonary credentials. Therefore, despite his lack of Board-certification in pulmonary disease, I find Dr. Rasmussen's qualifications to be comparable to those of a Board-certified pulmonary specialist.

Dr. Rasmussen examined Claimant on or about June 26, 2006, and issued a report, dated July 5, 2006 (CX 4). Dr. Rasmussen set forth Claimant's subjective complaints, past medical history, review of systems, habits, medications, family history, and, occupational history. On physical examination, Dr. Rasmussen stated, in pertinent part: "Chest expansion seemed diminished. Breath sounds are very markedly reduced. There were expiratory wheezes. No

rales." In addition, Dr. Rasmussen set forth the results of various clinical tests. In summary, Dr. Rasmussen stated:

> These studies indicate marked loss of lung function as reflected principally by his [Claimant's] marked ventilatory impairment. He does not retain the pulmonary capacity to perform his last regular coal mine job.
>
> The patient has a significant history of exposure to coal mine dust. He has radiographic changes consistent with pneumoconiosis. It is medically reasonable to conclude the patient has coalworkers' (sic) pneumoconiosis, which arose from his coal mine employment.
>
> The possible causes of [Claimant's] disabling lung disease first include his very significant smoking history of having smoked about ½ pack of cigarettes a day for around 61 years, and he has a history of at least 26 years of coal mine employment. There are no other apparent potential causes.

(CX 4). Following his discussion of epidemiologic studies which indicate that coal mine dust and cigarette smoke cause both independent and additive loss of lung function, Dr. Rasmussen stated:

> It is conceivable that all of [Claimant's] disabling chronic lung disease is the consequence of his coal mine dust exposure. It is also conceivable that all of [Claimant's] lung disease is the consequence of cigarette smoking, however, neither of those scenarios is realistic. The only reasonable conclusion is that his impairment is the consequence of both toxic substances.
>
> Although his lung tissue damage progressed as a result of his continued smoking habit, it also progressed as a consequence of the persistent alveolar inflammation or cellular chemical changes as a consequence of his coal mine dust exposure.
>
> [Claimant's] coal mine dust exposure is a significant contributing factor to his disabling chronic lung disease.
>
> [Claimant] has clinical pneumoconiosis, which contributes in a material fashion to his disabling lung disease.

(CX 4). Dr. Rasmussen also cited various articles of medical literature, and added an addendum, which summarized Dr. Cohen's evaluation of Claimant. In summary, Dr. Rasmussen stated:

> Not only were the findings [by Dr. Cohen] virtually the same, we reached the same conclusions concerning [Claimant's] disabling degree of lung disease and the causes. We both concluded that coal mine dust exposure was a significant contributing factor to [Claimant's] disabling lung disease and that he did have evidence of coalworkers' (sic) pneumoconiosis by radiographic findings.

(CX 4). Dr. Rasmussen reiterated the above-stated opinion in his deposition testimony on September 11, 2006 (EX 11). Dr. Rasmussen testified that, although he could not quantify the percentage of the roles caused by coal dust and cigarette smoking, Claimant would not be as disabled if he had never smoked, nor would he have been as disabled had he never been a coal miner. In summary, Dr. Rasmussen opined that Claimant's disabling lung disease is due to a combination of coal mine dust exposure and cigarette smoking (EX 11, pp. 20-23).

Discussion and Applicable Law

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under § 718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the record contains multiple, conflicting x-ray interpretations. The majority of recent x-ray interpretations by B-readers and/or Board-certified radiologists are positive for simple pneumoconiosis. Therefore, I find that Claimant has met his burden of establishing the presence of pneumoconiosis by a preponderance of the x-ray evidence, pursuant to § 718.202(a)(1).

Under § 718.202(a)(2), a finding of pneumoconiosis may be made on the basis of biopsy or autopsy evidence. In the absence of any such evidence, this subsection is not applicable.

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, I find that the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 does not apply to living miner's claims. Therefore, Claimant cannot establish pneumoconiosis under § 718.202(a)(3).

Under § 718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Pneumoconiosis is defined in § 718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. § 718.202(a)(1) and (2).

As outlined above, the case file contains recent hospital and treatment records (EX 1, 6). As previously stated, these records do not specify a diagnosis of pneumoconiosis. However, they also do not preclude a finding of pneumoconiosis. The crux of this case rests on the relative weight accorded to the medical opinions of Drs. Celko (DX 16; EX 7), Renn (EX 2; EX 15), Cohen (CX 1), Fino (EX 8, 11), and Rasmussen (CX 4; EX 12).

Of the foregoing, Drs. Celko, Cohen, and Rasmussen all found that Claimant suffers from (clinical and legal) pneumoconiosis and that the disease, in combination with cigarette smoking, has caused Claimant's totally disabling pulmonary or respiratory impairment. On the other hand,

Drs. Renn and Fino opined that Claimant does not suffer from pneumoconiosis and that Claimant's coal mine dust exposure has not caused or contributed to his total (pulmonary or respiratory) disability.

As fact-finder, I have conducted a qualitative assessment of the conflicting medical opinion evidence by analyzing the credibility of each medical opinion considered as a whole, in light of that physician's credentials, documentation, and reasoning. Of the above-named physicians, Drs. Cohen, Renn, and Fino are all Board-certified pulmonary specialists. Furthermore, as discussed above, I find that Dr. Rasmussen's impressive pulmonary credentials are comparable to those of a Board-certified pulmonary specialist. On the other hand, Dr. Celko's pulmonary qualifications are somewhat less impressive. Notwithstanding some inconsistencies in reported occupational and smoking histories, I find that the opinions of all of the above physicians, on their face, are reasoned and documented. However, based upon my further analysis of the respective opinions, I find that the opinions of Drs. Cohen and Rasmussen, as buttressed by Dr. Celko, are better reasoned and documented than those of Drs. Renn and Fino.

In making this determination, I initially note that Dr. Renn reported that "spirometry reveals a severe obstructive ventilatory defect that does significantly improve following inhaled bronchodilator." However, the post-bronchodilator pulmonary function study was still qualifying. Moreover, the other examining physicians reported less significant post-bronchodilator improvement, if any. Furthermore, while Dr. Fino concluded that coal mine dust did not cause, contribute, or hasten Claimant's disability, he also cited studies which indicated a measurable loss of FEV1 value due to coal mine dust exposure. The latter suggests that, although Claimant's long history of tobacco abuse may, in itself, be sufficient to cause total disability, that the totally disabling respiratory or pulmonary impairment has been worsened by such coal dust exposure. In addition, I find that Dr. Fino's report mischaracterized Claimant's coal mine employment, stating, in pertinent part, "he does not have a prolonged period of time within the coal mines." (EX 8, p. 14). To the contrary, I find that Claimant's 26-year coal mine employment history constitutes a prolonged period of time. Furthermore, I find that the opinions of Drs. Rasmussen, Cohen, and Celko are more consistent with the credible objective clinical data, including the preponderance of the positive x-ray evidence and the qualifying pulmonary function studies before and after bronchodilators, and more consistent with Claimant's significant history of coal mine employment. In view of the foregoing, I find that Claimant has also established pneumoconiosis under § 718.202(a)(4).

I have also weighed all the relevant evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from pneumoconiosis. In summary, the preponderance of the x-ray evidence and the more probative medical opinion evidence establish (clinical and legal) pneumoconiosis. Therefore, I find that the existence of pneumoconiosis has been established under 20 C.F.R. § 718.202(a). *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000); *see also*, *Penn Allegheny Coal Co. v. Williams,* 114 F.3d 22 (3d Cir. 1997).

Causal Relationship

Since Claimant has established the presence of pneumoconiosis, he is entitled to the rebuttable presumption that the disease arose from his more than ten years of coal mine employment. 20 C.F.R. § 718.203. This presumption has not been rebutted. However, in order to be eligible for benefits, Claimant still must establish that he suffers from a totally disabling pulmonary or respiratory impairment and that such total disability is due to pneumoconiosis.

Total Disability

The Regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time. *See* 20 C.F.R. § 718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. § 718.204(b)(2)(i)-(iv).

As outlined above, all of the recent pulmonary function tests are qualifying under the standards stated in Part 718, Appendix B. Therefore, Claimant has established total disability pursuant to § 718.204(b)(2)(i).

None of the recent arterial blood gas studies are qualifying under the criteria set forth in Part 718, Appendix C. Therefore, Claimant has not established total disability under § 718.204(b)(2)(ii).

Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant cannot establish total disability pursuant § 718.204(b)(2)(iii).

Under § 718.204(b)(2)(iv), total disability may also be found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine work or comparable and gainful work.

As summarized above, virtually all of the physicians of record who addressed the total disability issue agree that Claimant suffers from a severe pulmonary or respiratory impairment, which would preclude him from performing his last usual coal mine job or comparable work. In view of the foregoing, I find that Claimant has also established total disability under § 718.204(b)(2)(iv).

Taken as a whole, I find that, despite the nonqualifying arterial blood gas studies, the pulmonary function studies and medical opinion evidence clearly establish that Claimant is totally disabled pursuant to § 718.204(b).

Total Disability Due to Pneumoconiosis

Although Claimant has established that he suffers from pneumoconiosis arising from coal mine work and that he is totally disabled by his pulmonary or respiratory impairment, he still has the burden of establishing that the total disability is due to pneumoconiosis. 20 C.F.R. § 718.204(c).

Under the provisions of § 718.204(c)(1), "a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment" (*i.e.,* pneumoconiosis had a material adverse effect on the miner's respiratory or pulmonary condition or it materially worsened a totally disabling respiratory or pulmonary condition which was caused by a disease or exposure unrelated to coal mine employment). Furthermore, the cause or causes of the Claimant's total disability shall be established by means of a documented and reasoned physician's opinion. *See* 20 C.F.R. § 718.204(c)(2).

For the reasons outlined above, I accord the most weight to the opinions of Drs. Cohen and Rasmussen, which are supported by that of Dr. Celko, over the contrary opinions of Drs. Renn and Fino. Accordingly, I find that the better reasoned medical opinion evidence establishes that Claimant's occupational coal dust exposure (*i.e.,* pneumoconiosis) is a substantially contributing cause of his total disability. In view of the foregoing, I find that Claimant has established total disability due to pneumoconiosis under § 718.204(c).

Subsequent Claim

20 C.F.R. § 725.309 of the revised Regulations states, in pertinent part:

> (d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (*see* § 725.502(a)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement . . . has changed since the date upon which the order denying the prior claim became final . . . . The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based . . . .

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in the prior claim, except those based on a party's failure to contest an issue (see §725.463), shall be binding on any party in the adjudication of the subsequent claim . . . .

20 C.F.R. § 725.309(d)(1)-(4).

As stated above, the District Director issued the most recent, final denial of the prior closed claims, in the Proposed Decision and Order dated November 14, 2002 (DX 3). At that time, the District Director found that Claimant did not establish the requisite elements of entitlement. As set forth above, I find that the more recent medical evidence establishes all of the elements of entitlement. Moreover, in view of the progressive and irreversible nature of pneumoconiosis, I accord greater weight to the more probative recent medical evidence than the earlier medical evidence, which was submitted in conjunction with the prior closed claims filed in 1995, 1997, and 2001 (DX 1, 2, 3). Accordingly, I find that Claimant has clearly established a change in at least one of the applicable conditions of entitlement under § 725.309(d)(3).

Modification Under 20 C.F.R. § 725.310

As set forth above, Claimant filed the current claim on March 10, 2004 (DX 5), and the District Director initially denied the claim, in a Proposed Decision and Order dated January 18, 2005 (DX 30). However, on June 6, 2005, the District Director's office issued a Proposed Decision and Order Granting Request for Modification, in which benefits were awarded (DX 36). Based upon my analysis of the evidence, as outlined above, I find that the District Director properly corrected a mistake in a determination of fact. Therefore, the District Director's granting of Claimant's modification request was appropriate under § 725.310.

Conclusion

Having considered all of the evidence of record, I find that Claimant has established the presence of simple pneumoconiosis arising from his coal mine employment; he is totally disabled as defined in the Act and Regulations; and, pneumoconiosis is a substantial contributing cause of such total disability. Therefore, Claimant is entitled to benefits under the Act.

Commencement of Entitlement to Benefits

The medical evidence submitted in conjunction with the prior claims suggests that Claimant may have suffered from a totally disabling respiratory impairment due, in significant part, to pneumoconiosis, at some period prior to filing the current claim (DX 1, 2, 3). However, the older evidence is less conclusive and not as probative as the medical evidence submitted in conjunction with the current claim. Therefore, I find that the evidence does not establish the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Accordingly, benefits shall commence as of March 1, 2004, beginning with the month during which the miner filed his claim. 20 C.F.R. § 725.503(b). The benefits are to be appropriately augmented by reason of his dependent spouse.

Representative's Fees

No award of representative's fees for services to Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's representative for the submission of such application. His attention is directed to 20 C.F.R. § 725.365 and § 725.366 of the Regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of E.M. for benefits under the Black Lung Benefits Act is hereby **GRANTED.**

It is **ORDERED** that Consolidation Coal Company shall pay to Claimant, E.M., all benefits to which he is entitled under the Act, augmented by reason of his dependent spouse, as heretofore identified, commencing as of March 1, 2004.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Notice of public hearing: By statute and regulation, black lung hearings are open to the public. 30 U.S.C. § 932(a)(incorporating 33 U.S.C. § 923(b)); 20 C.F.R. § 725.464. Under e-FOIA, final agency decisions are required to be made available vial telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). It is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.